

Exhibit A

Lawrence Lind, M.D.

Page 1

1 UNITED STATES DISTRICT COURT

2 SOUTHERN DISTRICT OF WEST VIRGINIA

3 AT CHARLESTON

4 -----:
5 IN RE ETHICON, INC., PELVIC :
REPAIR SYSTEM PRODUCTS : MASTER FILE
LIABILITY LITIGATION : No. 2:12-MD-02327

6 _____ :
7 THIS DOCUMENT RELATES TO ALL : MDL 2327
WAVE 6 AND SUBSEQUENT WAVE : JOSEPH R. GOODWIN
8 CASES AND PLAINTIFFS: : US DISTRICT JUDGE

9 Beth Ann Bradley :
Case No. 2:13-cv-02058 :
10 Naomi Shelton :
Case No. 2:12-cv-09250 :
11 Patricia Volpe :
Case No. 2:13-cv-02051 :
12 -----

13 October 11, 2017

14 - - -

15 Deposition of LAWRENCE LIND, M.D.,
16 held at The Inn at Great Neck, 90 Cutter
17 Mill Road, Great Neck, New York, commencing
18 at 7:30 a.m., on the above date, before
19 Marie Foley, a Registered Merit Reporter,
20 Certified Realtime Reporter and Notary
21 Public.

22 - - -

23 GOLKOW LITIGATION SERVICES
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2 (Pages 2 to 5)

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<p>1 A. It's LIJ. 2 Q. And that's Long Island Jewish? 3 A. Correct. 4 Q. Okay. 5 A. And they have, for the record, 6 changed their name to Northwell Health. 7 So that name North Shore/LIJ at present 8 doesn't exist. It's just a branding and 9 name change. 10 Q. The hospital that you're working 11 at at this point and where you're the 12 chief of the division of urogynecology and 13 pelvic reconstructive surgery, would you 14 describe that as a primary institution for 15 those conditions or a tertiary referral 16 hospital? 17 A. Tertiary. 18 Q. And what does that mean, for the 19 record? 20 A. It means it's an academic-based, 21 most highly trained location where doctors 22 from more than just the local community 23 would send patients for care. So it's the 24 go-to place for -- we receive patients</p>	<p>Page 18</p> <p>1 state, one or two in New Jersey, and 2 typically the lecture titles are modern 3 approaches to incontinent surgery or 4 modern approaches to pelvic prolapse 5 surgery. 6 Q. With your contributions to the 7 medical literature, at some point in your 8 background, be as it may your undergrad, 9 pre-medical education, your medical 10 education, and/or your training and 11 experience, have you been taught to employ 12 what some people might call the scientific 13 method? 14 A. Yes. 15 Q. Would that consist of, for 16 example, a hypothesis formation, followed 17 by testing, followed by conclusions, 18 followed by peer review publication, 19 followed by replication of the method when 20 applicable? 21 A. Yes. 22 Q. Would you agree that if a 23 portion of the scientific method is 24 lacking, then the entire scientific method</p>
<p>1 from Manhattan, Pennsylvania, New Jersey, 2 and further. So by tertiary, it typically 3 means a center that is super specialized 4 and a go-to place for difficult cases and 5 that sort of thing. 6 Q. Look at your CV, I see that you 7 have contributed to the peer-reviewed 8 medical literature; is that correct? 9 A. Yes. 10 Q. And have you published any 11 peer-reviewed articles regarding Gynemesh 12 or Prolift mesh transvaginal mesh devices? 13 A. No. 14 Q. Have you been asked to give any 15 lectures to national societies on Gynemesh 16 or Prolift mesh? 17 A. No. 18 Q. Have you been invited to be a 19 visiting professor at any academic 20 institution previously? 21 A. I have. 22 Q. And what position or topic were 23 you appointed? 24 A. Those invites were all within</p>	<p>Page 19</p> <p>1 itself comes into question? 2 A. Not exactly. 3 Q. Well, let's try to use examples. 4 For example, let's hypothesize 5 that a new methodology is published in the 6 medical literature and no one else is able 7 to or attempts to replicate that 8 methodology. 9 Would you consider, without 10 replication, the scientific method to have 11 been fulfilled? 12 A. I would consider two 13 possibilities. One is that if this is, 14 for instance, a surgical execution, that 15 that person had methods that were 16 different than the population or that 17 there was a problem replicating it and 18 that those results couldn't be 19 generalized. 20 Q. Have you held yourself out to be 21 an expert in the implantation of Gynemesh 22 and/or Prolift mesh at any national 23 society meeting? 24 A. No.</p>

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<p>1 small number of patients involved, what 2 weight do you place upon that study? 3 A. Well, you can have a small 4 number that's still powered adequately. 5 So the power has the tool of evaluating 6 certainly has significant value. The 7 smaller the number, the harder it is to 8 power a study, but there's no absolute 9 number getting to on the smaller side that 10 has me -- gives me concern. It's do those 11 numbers fit into a power analysis that 12 holds water.</p> <p>13 Q. When you're looking at studies 14 that you might review that are germane to 15 your area of specialty, do you look at the 16 follow-up as described within the study?</p> <p>17 A. Yes.</p> <p>18 Q. And how do you define 19 "follow-up"?</p> <p>20 A. Follow-up is how many months or 21 years have you looked at the data or 22 looked at the data a second or third time 23 to assess the medium- or long-term 24 efficacy. Something that has follow-up of</p>	<p>Page 30</p> <p>1 in material science? 2 A. Can I assume by that question 3 that you again would mean ending in a 4 degree? 5 Q. Let's just ask if you had any 6 formal training first in material 7 sciences. 8 A. I would say that I've had 9 numerous lectures and I've been working 10 with and listening to and reading 11 literature on material science as it 12 relates to pelvic prolapse surgery for 20 13 to 25 years. 14 Q. Do you consider yourself an 15 expert in the field of material sciences? 16 A. Yes. 17 Q. Have you ever conducted any 18 animal research involving a material such 19 as mesh? 20 A. Yes. Actually, it's current, 21 not published, but at present we have a 22 grant for a mesh model in rats. 23 Q. Is that polypropylene mesh? 24 A. It's polypropylene and a couple</p>
<p>1 one month of course is somewhat 2 meaningless and follow-up of one year, 3 five years, ten years gets to increasing 4 value, of course at the challenge of 5 completing that follow-up because you have 6 to get them all to come back.</p> <p>7 Q. Do you have any formal training 8 in pathology beyond medical school 9 classes?</p> <p>10 A. Can you define "formal"?</p> <p>11 Q. Leading to a position or a 12 degree.</p> <p>13 A. I don't have a degree in 14 pathology. I've not been trained to the 15 point to get a degree, but I routinely 16 read pathology reports and act on them to 17 the import of my patients' safety.</p> <p>18 Q. Now, when you say you read the 19 pathology reports, do you read the actual 20 histopathologist slides, or do you depend 21 upon the reading of the actual slides by 22 the pathologists?</p> <p>23 A. I read the reports.</p> <p>24 Q. Have you had any formal training</p>	<p>Page 31</p> <p>1 of others that are being assessed as well. 2 Q. This is one of those questions 3 that ends up in a list of stupid questions 4 that lawyers ask, but it's foundational. 5 And it's implanted within the 6 rat? 7 A. Yes. 8 Q. Is it implanted in the pelvis of 9 the rat or on the dorsum? 10 A. Both. 11 Q. Have you ever conducted any 12 animal research utilizing Prolift mesh? 13 A. No. 14 Q. Gynecare mesh? 15 A. No. 16 Q. Have you conducted an 17 epidemiological study utilizing Prolift 18 mesh? 19 A. A study resulting towards a 20 publication, no, but I want to be careful 21 with that word since I've certainly 22 studied many things that would be called 23 epidemiology having to do with Prolift in 24 terms of studies, efficacy, safety. So I</p>

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<p>1 undergo a native tissue surgical repair 2 (other than colpocleisis) will require 3 re-operation for re-prolapse."</p> <p>4 Did I read that portion 5 correctly?</p> <p>6 A. Yes.</p> <p>7 Q. And then you state: "The 8 success rates for native tissue surgical 9 repairs decline over time. The failure 10 rate of native tissue surgical repairs is 11 widely reported to be about 40 percent."</p> <p>12 Do you see where I was reading 13 from there, sir?</p> <p>14 A. Yes.</p> <p>15 Q. Now, the statement that 16 approximately 30 percent who undergo a 17 native tissue surgical repair will require 18 re-operation for re-prolapse, there isn't 19 a reference for that statement; is that 20 correct?</p> <p>21 A. No, but the subsequent sentences 22 describe, you know, from 40 to as high as 23 70. So the 30 percent doesn't have a 24 specific reference there.</p>	<p>Page 46</p> <p>1 and scientific certainty and probability."</p> <p>2 Down about four lines you write 3 that you "...place a special emphasis on 4 randomized control trials, systemic 5 reviews and meta-analyses which provide 6 the highest levels of scientific 7 evidence."</p> <p>8 Do you see where I read from, 9 sir?</p> <p>10 A. Yes.</p> <p>11 Q. And that's what we discussed 12 earlier in the deposition about the 13 hierarchy of epidemiology, correct?</p> <p>14 A. Correct.</p> <p>15 Q. And you have read the systemic 16 review that's been published by Maher, et 17 al. in Cochrane that is titled 18 "Transvaginal mesh or grafts compared with 19 native tissue repair for vaginal prolapse 20 (review)"?</p> <p>21 A. I have read it, yes.</p> <p>22 Q. And you are relying upon it for 23 basis of several of your opinions in this 24 expert report; is that correct?</p>
<p>1 Q. And what is the basis for your 2 opinion that success rates for native 3 tissue surgical repairs decline over time?</p> <p>4 A. Multiple articles. 20 years of 5 experience.</p> <p>6 Q. Now, if you were submitting this 7 expert report for publication in the 8 peer-reviewed literature, would you agree 9 that a statement like that would require a 10 reference?</p> <p>11 A. So, a reference was missing and 12 I would fill it in.</p> <p>13 Q. Now, you're familiar with the 14 Cochrane database of systemic reviews; is 15 that correct?</p> <p>16 A. Yes.</p> <p>17 Q. In fact, on page 3 of your 18 report, you have a section 2 which is 19 titled "Materials Reviewed."</p> <p>20 Is that correct?</p> <p>21 A. Page 3, section 2, yes.</p> <p>22 Q. In the paragraph that starts: 23 "I hold the opinions set forth in this 24 report to a reasonable degree of medical</p>	<p>Page 47</p> <p>1 A. Yes.</p> <p>2 Q. When I downloaded this document, 3 I noted it to be 142 pages long with a lot 4 of material.</p> <p>5 Did you read this systemic 6 review in its entirety?</p> <p>7 A. Every single word, no, but most 8 of it, yes.</p> <p>9 MR. RESTAINO: Now, in order to 10 save trees, I haven't printed out all 11 142 pages, but I've taken 12 representative sections and I've put 13 the cover page on each front.</p> <p>14 So, for the first one that's 15 going to consist of the table of 16 contents and pages 1 and 2, I'll have 17 the court reporter mark this as 18 Exhibit 8.</p> <p>19 (Lind Exhibit Lind Exhibit 8, 20 Cochrane Library Maher article 21 excerpt, was marked for 22 identification, as of this date.)</p> <p>23 BY MR. RESTAINO:</p> <p>24 Q. And you have seen this before,</p>

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<p>1 it not?</p> <p>2 A. The study is randomized, which</p> <p>3 as we both know is best designed to</p> <p>4 minimize bias. Despite randomization, in</p> <p>5 this study you have more people in one</p> <p>6 group with a previous sacrocolpopexy than</p> <p>7 the other.</p> <p>8 If you look down further, you</p> <p>9 have people, you have more patients with</p> <p>10 more than one previous surgery in the</p> <p>11 conventional group. So, you know, it goes</p> <p>12 both ways.</p> <p>13 I think to me the key element</p> <p>14 for prolapse surgery is are the stages of</p> <p>15 prolapse similar, which they are in this</p> <p>16 study 'cause that's what you're starting</p> <p>17 with. If you have a stage 3 prolapse of a</p> <p>18 sacrocolpopexy, the bias that we're trying</p> <p>19 to discuss for a group that would have had</p> <p>20 more that would have had a previous</p> <p>21 support procedure would mean, well, she</p> <p>22 already has some support from the previous</p> <p>23 surgery, so that would lead towards</p> <p>24 possibly a better outcome for her having</p>	<p>Page 82</p> <p>1 think the fact that they're exactly</p> <p>2 matched by their randomization in prolapse</p> <p>3 stage makes that bias that you've pointed</p> <p>4 out not clinically significant or</p> <p>5 scientifically significant for me.</p> <p>6 Q. Earlier we had discussed the</p> <p>7 hierarchy of scientific evidence and you</p> <p>8 had placed the meta-analysis and systemic</p> <p>9 review at the top of that, correct?</p> <p>10 A. Yes.</p> <p>11 Q. And we've been talking about the</p> <p>12 Cochrane 2016 study, which I have shared</p> <p>13 with you that I did not print out all 142</p> <p>14 pages.</p> <p>15 MR. RESTAINO: I'm going to ask</p> <p>16 the court reporter to now mark again</p> <p>17 front page indicating that it is the</p> <p>18 2016 Cochrane Review, but I only</p> <p>19 printed out for these purposes pages</p> <p>20 12, 13 and 14.</p> <p>21 (Lind Exhibit 13, Cochrane</p> <p>22 Library excerpt pages 12, 13 and 14,</p> <p>23 was marked for identification, as of</p> <p>24 this date.)</p>
<p>1 the second surgery 'cause she's having the</p> <p>2 added help of the first surgery. But if</p> <p>3 someone has a stage 2 or 3 prolapse, the</p> <p>4 sacrocolpopexy has completely detached.</p> <p>5 It cannot possibly be that low if it's</p> <p>6 still attached.</p> <p>7 So I would consider that to be</p> <p>8 from a pure research design standpoint,</p> <p>9 your point is reasonable, but if you apply</p> <p>10 it to the actual clinical scenario, are</p> <p>11 these patients the same, if a patient has</p> <p>12 stage 2 or stage 3 prolapse, she doesn't</p> <p>13 have a sacrocolpopexy anymore. The only</p> <p>14 thing the sacrocolpopexy would do to bias</p> <p>15 that group differently from an outcome</p> <p>16 standpoint is that she's got a piece of</p> <p>17 mesh on the other side of the vagina. So</p> <p>18 hypothetically, she could have increased</p> <p>19 risk of mesh problems because she has a</p> <p>20 piece of mesh on the other side of the</p> <p>21 vagina as well.</p> <p>22 So, I think your point is valid</p> <p>23 from a pure statistical design, but as you</p> <p>24 apply it to urogynecology and prolapse, I</p>	<p>Page 83</p> <p>1 BY MR. RESTAINO:</p> <p>2 Q. If you would turn to page 14,</p> <p>3 they have a paragraph on 14 that starts</p> <p>4 off with: "We rated 18 studies."</p> <p>5 Do you see that?</p> <p>6 A. Which paragraph?</p> <p>7 Q. I didn't write it down for</p> <p>8 myself. You want to hand it to me. I'll</p> <p>9 try to save you a little eye strain.</p> <p>10 (Pause.)</p> <p>11 It's the second paragraph under</p> <p>12 "Allocation."</p> <p>13 A. Okay.</p> <p>14 Q. (Reading) "We rated 18 studies</p> <p>15 that did not describe an adequate method</p> <p>16 of allocation concealment as at unclear</p> <p>17 risk in this domain, and we rated two</p> <p>18 studies as at high risk of bias, as they</p> <p>19 either did not use allocation concealment,</p> <p>20 in Tamanini 2014, or we suspected a high</p> <p>21 potential for bias (Withagen 2011.)"</p> <p>22 Did I read that correctly?</p> <p>23 A. Yes.</p> <p>24 Q. And the Withagen 2011 is what we</p>

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<p>1 or all of the opinions there. They may 2 agree with some, they may disagree with 3 some. You have new information, so it 4 gets updated. 5 So, when things get pulled down, 6 it means that the committee has made a 7 topic paper or a committee opinion that's 8 more updated and then that one usually 9 replaces it. 10 Q. Does the same apply for when 11 they withdraw committee opinions from the 12 Journal of Obstetrics and Gynecology? 13 A. I don't know what those criteria 14 are. 15 MR. RESTAINO: I'm going to ask 16 the court reporter to mark page 17 documenting that this document has 18 been withdrawn or is no longer 19 available through the Journal of 20 Obstetrics and Gynecology. 21 (Lind Exhibit 16, American 22 College of Obstetricians and 23 Gynecologists Women's Health Care 24 Physicians document withdrawal, was</p>	<p>Page 102</p> <p>1 the most up-to-date. 2 So I'm going to hypothesize that 3 this is removed simply because there was 4 something more up-to-date and it 5 doesn't -- and it probably, and again 6 opinion only, that it probably does not 7 carry any significance in terms of not 8 being accurate as of 2011. 9 Q. Am I safe in understanding that 10 your hypothesis is also a form of 11 speculation as much as you don't know why 12 they pulled this article down, do you? 13 A. I would say my hypothesis is 14 based on the fact that I get committee 15 opinions, and in committee opinions that 16 are newer it states, and I specifically 17 know, specifically it states this 18 committee opinion replaces number 19 so-so-so. So, in 20 years of getting 20 committee opinions, I get replacements and 21 it says this replaces the previous one. 22 MR. RESTAINO: I'm going to ask 23 the court reporter to mark as next the 24 ACOG Practice Advisory on the FDA's</p>
<p>1 marked for identification, as of this 2 date.) 3 BY MR. RESTAINO: 4 Q. Sir, did you have a response? 5 A. I do. I do. 6 As of right now, you may or may 7 not know what the criteria are or reasons 8 for removing are. 9 In my world, I want to make sure 10 we're clear, and for the statement here on 11 the record that withdrawal here, at least 12 based on the information in this room, 13 doesn't confer anything that suggests that 14 the information that that contained as 15 published as of that time had any 16 problems, was thought to be incorrect or 17 withdrawn because it was inaccurate. It's 18 going to be my suggestion, which is a 19 hypothesis, not truth, that these are 20 informational. They're educational, and 21 when we have more information and we 22 update our education, ACOG tends to 23 replace things so that students, residents 24 are not reading older versions; they get</p>	<p>Page 103</p> <p>1 Reclassification of Mesh For Pelvic 2 Organ Prolapse dated January 6, 2016. 3 (Lind Exhibit 17, ACOG Practice 4 Advisory on the FDA's Reclassification 5 of Mesh For Pelvic Organ Prolapse 6 dated January 6, 2016, was marked for 7 identification, as of this date.) 8 BY MR. RESTAINO: 9 Q. And you would agree that 2016, 10 sir, is after 2011, correct? 11 A. Yes. 12 Q. And in this practice advisory 13 dated January 6, 2016 on point number 1 14 they write: "The FDA reclassified these 15 medical devices from Class 2, which 16 generally includes moderate-risk devices, 17 to Class 3, which generally includes high 18 risk devices." 19 Did I read that correctly? 20 A. Yes. 21 Q. Now, while mentioning the ACOG 22 committee opinion from 2011 in your expert 23 report, you do not mention in your expert 24 report that ACOG in 2016 notes that these</p>

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<p>1 interventional, which is a surgical 2 revision, whether it be in the office with 3 no anesthesia, in the office with local or 4 under general anesthesia.</p> <p>5 MR. RESTAINO: I'm going to ask 6 the court reporter now to mark a paper 7 that's in your general reliance list, 8 lead author is Sarah Abbott, 9 A-B-B-O-T-T, and the article is 10 "Evaluation and Management of 11 Complications From Synthetic Mesh 12 After Pelvic Reconstructive Surgery: 13 A Multicenter Study." 14 (Lind Exhibit 18, Abbott article 15 Evaluation and Management of 16 Complications From Synthetic Mesh 17 After Pelvic Reconstructive Surgery: 18 A Multicenter Study, was marked for 19 identification, as of this date.)</p> <p>20 BY MR. RESTAINO:</p> <p>21 Q. Sir, if you look at the abstract 22 under "Study Design For Foundational 23 Purposes" they write: "We conducted a 24 multicenter, retrospective analysis of</p>	<p>Page 110</p> <p>1 Q. I think so. 2 A. "Of those who were initially 3 treated non-surgically"? 4 "Of the women who initially had 5 in-office trimming"? 6 Q. Yes. 7 "Of the women who initially had 8 in-office trimming of mesh, 73.3 percent 9 eventually went to the operating room." 10 Did you see that, sir? 11 A. Yes. 12 Q. Now, again your expert report 13 states the majority of exposures can be 14 treated conservatively, whether 15 expectantly or with topical estrogen 16 cream, but these surgeons from these four 17 medical centers found that 73.3 percent of 18 these patients who undergo an in-office 19 trimming ended up in the operating room, 20 did they not? 21 A. The statements as they've 22 written statistically and their results 23 clearly are accurate. These are expert 24 researchers and expert surgeons.</p>	
<p>1 women who attended four U.S. tertiary 2 referral centers for evaluation of 3 mesh-related complications after surgery 4 for SUI and/or POP from January 2006 to 5 December 2010."</p> <p>6 And we discussed earlier what is 7 meant by a tertiary referral center; is 8 that correct, sir?</p> <p>9 A. Yes.</p> <p>10 Q. If you would turn to page 163.E6 11 of this Abbott study there's a top left 12 column that starts, continues over with 13 "Complication was 2 with a range of 1 to 14 9."</p> <p>15 Do you see where I'm reading 16 from?</p> <p>17 A. Yes.</p> <p>18 Q. Basically at the bottom of that 19 paragraph they write: "Of the women who 20 initially had an in-office." So I'm at 21 the bottom of the first paragraph, upper 22 right-hand column -- or top of left 23 column.</p> <p>24 A. Top of the left column?</p>	<p>Page 111</p> <p>1 From a research design 2 standpoint and with your professional 3 background and as we are trying to be true 4 to each other on design, this is as biased 5 as could be with the worst of the worst 6 case scenarios going to not just tertiary 7 centers.</p> <p>8 There are about 65 programs 9 training urogynecologists in the nation, 10 and you have four of the top, top, top 11 fly-across-the-country guys who are being 12 referred the worst of the worst of the 13 cases. So, from a numerator -- 14 denominator standpoint, this is just a 15 case series. And yes, it's 16 multi-centered, but it's four case series 17 lumped together of the people who are 18 known nationally, send this guy your 19 toughest case. So we're describing the 20 patients who didn't get better, the 21 patients who got better from topical 22 estrogen didn't get referred to the 23 centers. So we have selected only for the 24 people who failed in the worst case</p>	

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<p>1 Q. About five or six lines down 2 they start "First." 3 Do you see that? 4 A. Yes. 5 Q. (Reading) "First, approximately 6 one-half of the women (49.3 percent) who 7 sought treatment of a mesh related 8 complication at a tertiary referral center 9 actually underwent their index procedure 10 at a facility other than that tertiary 11 referral center." 12 And that's what you've been 13 saying, correct? 14 A. Yes. 15 Q. (Reading) "This trend has been 16 reported in other studies as well. 17 Reference 12. This raises the potential 18 concern that physicians who perform these 19 mesh procedures may not be aware of the 20 complications their patients experience 21 and that these providers may be 22 responsible for future mesh related 23 complications with no awareness of the 24 existing magnitude of the issue."</p>	<p style="text-align: right;">Page 118</p> <p>1 form. 2 A. I strongly disagree with the 46 3 percent which you're quoting from this 4 article, as I've stated previously, is a 5 cross-sectional collection of four case 6 series lumped together referred to four of 7 the top people in the nation and does not 8 represent the -- any of the percentages of 9 requiring mesh complete removals as based 10 on the stronger studies, randomized 11 studies, and from a statistical design 12 standpoint, to be quoting these as the 13 risk of total removal rate of 46 percent 14 is dismissing everything that we have both 15 learned in terms of statistical design and 16 what is legitimate to state as an overall 17 risk. 18 Q. But it is data, correct? 19 A. It is data of the worst cases 20 sent to the surgeons who take the cases 21 that no one else can take. That's biased 22 data. 23 MS. GERSTEL: The time is at two 24 hours.</p>
<p>1 Did I read that correctly? 2 A. Yes. 3 Q. Now, the impetus for this entire 4 line of questioning is you wrote in your 5 expert report that mesh complications are 6 typically mild and can be treated 7 expectantly, mesh erosion can be treated 8 expectantly and/or with estrogen cream, 9 but you don't put in your expert report 10 that there is a portion of women with the 11 same complications that undergo very 12 significant morbidity and surgical 13 correction, correct? 14 MS. GERSTEL: Object to form. 15 A. I think I do indicate in my 16 report that people do require surgery to 17 correct this. How detailed I get into on 18 how invasive the repairs are is not 19 detailed as specifically as the line of 20 questioning here. That's fair. 21 Q. Do you state for the judge the 22 percentage, almost 50 percent that have to 23 undergo a mesh excision in this situation? 24 MS. GERSTEL: Object to the</p>	<p style="text-align: right;">Page 119</p> <p>1 MR. RESTAINO: Why don't we go 2 ahead and take a break and go off the 3 record at this point? 4 (Recess taken at 9:41 a.m. to 5 10:22 a.m.) 6 BY MR. RESTAINO: 7 Q. Doctor, we're going to shift 8 gears and talk a little bit about TTVT. 9 MR. RESTAINO: Or is it 10 TTVT-Exact, or does it matter? 11 THE WITNESS: My statement I 12 think is on the TTVT-Exact. 13 MS. GERSTEL: Yes, but the 14 deposition is on TTVT. 15 MR. RESTAINO: Just TTVT? 16 MS. GERSTEL: Yes. 17 BY MR. RESTAINO: 18 Q. When did you start using the TTVT 19 product for the treatment of urinary 20 incontinence? 21 A. The late 1990s. 22 Q. Similarly as I asked you with 23 Gynemesh, have you ever had to remove a 24 TTVT mesh from a woman in total?</p>

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<p>1 about the same in the literature as when 2 we're doing them with native tissue. So 3 we can't point to the sling as this evil 4 tightening agent. What we don't have is 5 high level data that proves that mesh in 6 and of itself shrinks. 7 Q. So the record's clear, when you 8 say mesh in of itself shrinks -- 9 A. Does not shrink. 10 Q. Does not shrink, it's not the 11 material that shrinks, as in like I put a 12 cotton shirt in the dryer on high and the 13 shirt itself shrinks, but it's the soft 14 tissue around the mesh that contracts, in 15 effect shrinking the mesh, correct? 16 A. Even more to your side. You 17 can't tell what's what. They're in there 18 together all the time. The end result is 19 too tight. How much the -- is it the -- 20 does the mesh get tighter on its own, does 21 the wound get tighter on its own? I can't 22 tell. They're in there together. 23 Q. And have you looked at high 24 level RCTs and/or meta-analyses, systemic</p>	<p>Page 182</p> <p>1 be a few minutes of redirect. 2 EXAMINATION BY 3 MS. GERSTEL: 4 Q. Dr. Lind, I think we referenced 5 this earlier in your deposition. 6 You went to medical school at 7 Cornell; is that correct? 8 A. Yes. 9 Q. And you did your residency also 10 at Cornell; is that correct? 11 A. Cornell was the medical school 12 in charge of the academics of North Shore 13 LIJ, so that would be correct, yes. 14 Q. And then you did a fellowship in 15 urogynecology at UCLA; is that correct? 16 A. Correct. 17 Q. Doctor, can you tell us why you 18 decided to specialize in urogynecology? 19 A. I was a resident and I was 20 staying up all night delivering babies and 21 everyone told me I had good hands and 22 there was this organ in the middle of my 23 surgical field called the bladder and I 24 was told to be careful with it, you can</p>
<p>1 reviews comparing contracture, mesh 2 contracture incidence rates with tissue 3 incidence rates in the native tissue 4 repair? 5 That was a poorly-worded 6 question. Do you need me to repeat it? 7 A. The contracture I haven't looked 8 at, but when we have an enormous abundance 9 of data in the randomized, highest level, 10 most voluminous data is the incidence of 11 voiding dysfunction retention, which is 12 the result of things being too tight. You 13 know, you can have -- you can 14 hypothetically have pain, but really the 15 most objective thing you can measure is 16 voiding dysfunction and retention and 17 those studies show that it's equal or 18 better than the Burch. It shows that it's 19 less retention than the fascial sling, 20 which is the patient's own tissue. It's a 21 really good procedure. 22 MR. RESTAINO: I don't have any 23 further questions, Doctor. 24 MS. GERSTEL: I'm just going to</p>	<p>Page 183</p> <p>1 get into trouble, don't hurt it, stay away 2 from it, and there was a couple people I 3 had heard of in the nation and in our area 4 who had started working diligently in this 5 area on the first abdominal sacral 6 suspension in the world was done in room 8 7 where I operate every Monday, in the 8 world, Louis Lane, and it seemed very 9 clear that with an aging population, we 10 cured every other disease, people are 11 going to live longer, I have slides in my 12 lectures with old ladies working out, that 13 staying healthier and having pelvic organ 14 prolapse and incontinence was going to 15 become a much larger thing. I wanted to 16 use my hands. Oncology was too sad and 17 this was brand new, wide open field that 18 needed good people. When I applied, there 19 were five fellowships. Now there's 65. 20 Q. Doctor, I want to ask you some 21 questions about Gynemesh PS and then I'll 22 ask you some questions about TVT. 23 When did you first use Gynemesh 24 PS to treat pelvic organ prolapse?</p>

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<p>1 A. In the early 2000s, 2003, 4. 2 Q. How many times have you 3 implanted Gynemesh PS since then? 4 A. Hundreds. 5 Q. Do you have patients in whom you 6 have implanted Gynemesh PS whom you have 7 followed for years? 8 A. Absolutely. 9 Q. Have most of the patients in 10 whom you've implanted Gynemesh PS been 11 happy with the outcome of their surgeries? 12 A. Yes. 13 Q. And for most of them, has their 14 surgery with Gynemesh PS improved their 15 quality of life? 16 A. Absolutely. 17 Q. Would you use Gynemesh PS if 18 most patients in whom you implanted it did 19 not do well? 20 A. No. 21 Q. Doctor, is it your opinion that 22 Gynemesh PS is an important tool for 23 surgeons to have for repair of pelvic 24 organ prolapse?</p>	<p>Page 186</p> <p>1 data, deciphering through the tiers of 2 data so you can decide what's more 3 reliable, less reliable, what's flawed, 4 what's not flawed, making sure you're 5 up-to-date on the scientific readings, 6 education, and staying in touch with your 7 highest level committees that guide you to 8 make your decisions based on objective 9 information, proven studies, and doing 10 without being influenced by other 11 motivations. 12 Q. Do you practice evidence-based 13 medicine? 14 A. Absolutely. 15 Q. Can you explain how it's helpful 16 for your patients that you practice 17 evidence-based medicine? 18 A. I think it's, you know, I went 19 to a school where the fourth year there 20 were no pens and pencils in most of the 21 classes. You had to present yourself 22 verbally. And I think my patients when 23 they're done getting my counseling believe 24 that they have someone that was trained at</p>
<p>1 A. Yes. 2 Q. Why? 3 A. It's got an expert's hands. 4 It's got, you know, some of the highest 5 volume of literature on use for pelvic 6 prolapse. It's a type 1 mesh. And 7 certainly, you know, 15 years later, I 8 live in Great Neck, I got the most 9 obnoxious complaining population in the 10 nation. If it was causing trouble, it's 11 more important than any guideline in the 12 world if your patients, man, their five 13 sons are in your office breathing down 14 your neck, I can promise you on the record 15 here, there's powers much higher than any 16 of this legal stuff that seeing a family 17 upset on a bad outcome, it's not good in 18 this area. And it's been working. 19 Q. Doctor, can you tell us what is 20 evidence-based medicine? 21 A. Rather than just using 22 word-of-mouth, reading haphazardly here or 23 there a throw-away journal, you are making 24 decisions based on the highest tiers of</p>	<p>Page 187</p> <p>1 the highest level, who's honest, that's 2 making decisions based on really being 3 current with the literature and not being 4 influenced, and I think they feel very 5 confident. 6 Q. Doctor, switching to TVT. 7 When did you first use TVT? I 8 think you actually were asked this 9 earlier, but if you could just remind us. 10 A. Late in the 1990s, '98, '99. 11 Q. I believe you said you've 12 implanted approximately 3,000 TVTs since 13 then; is that correct? 14 A. Three thousand midurethral 15 slings. 16 Q. Are you able to say what 17 percentage of those were TVTs? 18 A. About half of them were TVTs. 19 Q. Do you have patients in whom 20 you've implanted TVT that you have 21 followed for years? 22 A. Yes. 23 Q. And have most of your patients 24 in whom you've implanted TVT been happy</p>

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1 C E R T I F I C A T E
2 STATE OF NEW YORK
3 COUNTY OF NEW YORK
4
5 I, Marie Foley, RMR, CRR, a
6 Certified Realtime Reporter and Notary
7 Public within and for the State of New
8 York, do hereby certify:
9 THAT LAWRENCE LIND, M.D., the
10 witness whose deposition is hereinbefore
11 set forth, was duly sworn by me and that
12 such deposition is a true record of the
13 testimony given by the witness.
14 I further certify that I am not
15 related to any of the parties to this
16 action by blood or marriage, and that I am
17 in no way interested in the outcome of
18 this matter.
19 IN WITNESS WHEREOF, I have
20 hereunto set my hand this 14th day of
21 October, 2017.

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LAWYER'S NOTES

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